

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

June 2022 Grand Jury

UNITED STATES OF AMERICA,

Plaintiff,

v.

LOURDES NAVARRO,
aka "Lulu,"

Defendant.

CR 2:22-CR-154-SB -2

F I R S T
S U P E R S E D I N G
I N D I C T M E N T

[18 U.S.C. § 1349: Conspiracy to Commit Health Care Fraud and Wire Fraud; 18 U.S.C. § 1347: Health Care Fraud; 18 U.S.C. § 1956(h): Conspiracy to Commit Money Laundering; 18 U.S.C. § 1001(a)(3): False Statements; 18 U.S.C. §§ 982(a)(1) and 982(a)(7): Criminal Forfeiture]

1 The Grand Jury charges:

2 COUNT ONE

3 [18 U.S.C. § 1349]

4 A. INTRODUCTORY ALLEGATIONS

5 At times relevant to this First Superseding Indictment:

6 1. 'Matias' Clinical Laboratory, Inc., doing business as
7 ("dba") Health Care Providers Laboratory ("Matias"), was a clinical
8 testing laboratory located at 14411 Palmrose Avenue, Baldwin Park,
9 California 91706, within the Central District of California.

10 2. Defendant LOURDES NAVARRO, also known as "Lulu," was a
11 resident of Glendale, California, within the Central District of
12 California, and New York.

13 3. Defendant NAVARRO and her husband, Imran Shams ("Shams"),
14 owned, controlled, and operated Matias.

15 4. Individual A and Individual B were, at various times,
16 listed on business records and corporate filings submitted by Matias
17 as President, Vice President, and Chief Financial Officer of Matias.

18 5. Until in or around May 2019, Matias maintained a bank
19 account at Wells Fargo Bank, N.A. with an account number ending in
20 7139 ("WF x7139"). Beginning in or around May 2019 and continuing to
21 at least April 2022, Matias maintained a bank account at East West
22 Bank with an account number ending in 5549 ("EW x5549"). Defendant
23 NAVARRO and Shams controlled the WF x7139 and EW x5549 bank accounts.

24 6. Wells Fargo Bank, N.A. and East West Bank were financial
25 institutions as defined in 18 U.S.C. § 20.

26 The Medicare Program

27 7. The Medicare program ("Medicare") was a federally funded
28 health insurance program, affecting commerce, that provided benefits

1 to individuals who were 65 years and older, and to certain disabled
2 persons. Medicare was administered by the Centers for Medicare and
3 Medicaid Services ("CMS"), a federal agency under the United States
4 Department of Health and Human Services ("HHS"). Medicare was a
5 "health care benefit program" as defined in 18 U.S.C. § 24(b) in that
6 it was a public plan or contract affecting commerce, and a "Federal
7 health care program" as defined by 42 U.S.C. § 1320a-7b(f).

8 8. Individuals who qualified for Medicare benefits were
9 referred to as Medicare "beneficiaries." Medicare beneficiaries were
10 issued beneficiary identification cards that certified eligibility
11 for Medicare and identified each beneficiary by a unique number.

12 9. Physicians, clinical laboratories, and other health care
13 providers that provided medical services to beneficiaries that were
14 to be reimbursed by Medicare were referred to as Medicare "providers"
15 and "suppliers."

16 10. Medicare was divided into different program "parts." Part
17 A covered health services provided by hospitals, skilled nursing
18 facilities, hospices, and home health agencies; Part B was a medical
19 insurance program that covered, among other things, medical services
20 provided by physicians, medical clinics, and laboratories; and Part
21 C, known as the Medicare Advantage Program, provided Medicare
22 beneficiaries with the option to receive their Medicare benefits
23 through private managed care plans rather than through Parts A and B.

24 11. Private health insurance companies offering Medicare
25 Advantage plans were required to provide Medicare beneficiaries with
26 the same services and supplies offered under Medicare Parts A and B.
27 To be eligible to enroll in a Medicare Advantage plan, a person had
28 to have been entitled to benefits under Medicare Parts A and B.

1 Medicare Coverage

2 12. Medicare paid for claims only if the items or services were
3 medically necessary for the treatment or diagnosis of the
4 beneficiary's illness or injury, documented, and actually provided as
5 represented. Medicare would not pay for items or services that were
6 procured through kickbacks and bribes.

7 13. On January 31, 2020, HHS declared that, in light of
8 confirmed cases of novel coronavirus disease 2019, commonly referred
9 to as "COVID-19," a public health emergency existed nationwide.

10 14. In or around May 2020, in response to the public health
11 emergency for the COVID-19 pandemic, Medicare removed the requirement
12 that COVID-19 tests and certain, defined respiratory pathogen tests
13 be ordered by a treating physician. Under the interim policy,
14 Medicare covered COVID-19 tests and certain, defined respiratory
15 pathogen tests when ordered by any health care professional
16 authorized to do so under state law. Under the interim policy,
17 COVID-19 tests and respiratory pathogen tests still had to be
18 reasonable and medically necessary for the treatment of illness or
19 injury, eligible for reimbursement, provided as documented, and not
20 procured through the payment of kickbacks and bribes in order to be
21 covered by Medicare.

22 Medicare Enrollment

23 15. In order to receive payment for covered items and services
24 furnished to Medicare beneficiaries, providers and suppliers,
25 including clinical laboratories, were required to submit a Medicare
26 enrollment application, CMS Form 855B, in which the supplier
27 certified its compliance with all Medicare-related laws and
28 regulations, including the Federal Anti-Kickback Statute, 42 U.S.C.

1 § 1320a-7b(b), which prohibited the offering, paying, soliciting, or
2 receiving of any remuneration in exchange for a patient referral or
3 the referral of other business for which payment may be made by any
4 Federal health care program. Providers and suppliers further agreed
5 not to submit claims for payment to Medicare knowing they were false
6 or fraudulent or with deliberate ignorance or reckless disregard of
7 their truth or falsity. If Medicare approved the application, the
8 providers and suppliers were permitted to submit claims to Medicare
9 for reimbursement for services provided to Medicare beneficiaries.

10 16. In order to maintain active enrollment status, and as a
11 condition of participation in Medicare, a clinical laboratory was
12 required to report changes in enrollment information that involved
13 any change of ownership or control interest within 30 days. 42
14 U.S.C. § 1320a-3; 42 C.F.R. § 424.516(e)(1). A clinical laboratory
15 was also required to certify that it did not employ an individual who
16 had been excluded from participation in Medicare. 42 C.F.R. §
17 424.516(a)(3)(i).

18 17. A person with an "ownership or control interest" was
19 defined, with respect to an entity, as a person with a direct or
20 indirect ownership interest of five percent or more, or an officer or
21 director of the entity. 42 U.S.C. §§ 1320a-3(a)(3)(A)(i), (B). A
22 managing employee was defined as a "general manager, business
23 manager, administrator, director, or other individual that exercises
24 operational or managerial control over, or who directly or indirectly
25 conducts, the day-to-day operation of the provider or supplier,
26 either under contract or through some other arrangement, whether or
27 not the individual is a W-2 employer of the provider or supplier.
28 42 C.F.R. § 424.502.

1 18. For certain types of suppliers, including clinical
2 laboratories, the application to enroll in Medicare or make changes
3 to enrollment was known as Form CMS-855B. Among other information,
4 Form CMS-855B contained spaces for a provider to identify persons who
5 have five percent or greater direct or indirect ownership interest,
6 and all managing employees, including "a general manager, business
7 manager, administrator, director, or other person who exercises
8 operational or managerial control over, or who directly or indirectly
9 conducts, the day-to-day operations . . . regardless of whether the
10 individual is a W-2 employee of the supplier." Form CMS-855B further
11 provided space for disclosure of any final adverse legal action,
12 including the federal or state agency or court/administrative body
13 that imposed an action, against any of the persons identified as
14 having ownership interest and/or managing control of the provider.

15 19. Certain suppliers, including clinical laboratories, were
16 required to resubmit and recertify the accuracy of their enrollment
17 information every five years. Among the types of information
18 required to be provided were changes in ownership interest and/or
19 managing control, including listing individuals who were five percent
20 or greater direct/indirect owners, authorized or delegated officials,
21 partners, directors/officers, contracted managing employees, and
22 managing employees. 42 C.F.R. § 424.515. Form CMS-855B also
23 required disclosure of whether any individuals who were added as
24 persons with ownership interest and/or managing control were the
25 subject of final adverse legal action as described above.

26 The HRSA COVID-19 Uninsured Program

27 20. The Families First Coronavirus Response Act ("FFCRA") was a
28 federal law enacted on or about March 14, 2020, as part of the

1 federal government's initial response to the then-emerging COVID-19
2 pandemic.

3 21. The FFCRA, among other things, appropriated funds to
4 reimburse the cost of providing diagnostic testing and services for
5 COVID-19 in individuals without health insurance. These funds, and
6 additional funds appropriated through subsequent legislation for
7 testing, treatment, and vaccines for uninsured individuals, were
8 distributed through the COVID-19 Claims Reimbursement to Health Care
9 Providers and Facilities for Testing, Treatment, and Vaccine
10 Administration for the Uninsured Program ("HRSA COVID-19 Uninsured
11 Program").

12 22. The HRSA COVID-19 Uninsured Program was administered by HHS
13 through its agency, the Health Resources and Services Administration
14 ("HRSA"). HRSA contracted with UnitedHealth Group, a private
15 insurance company, to handle claims administration and payments,
16 which UnitedHealth Group performed through its unit Optum Health.
17 Reimbursements by HRSA were provided on a rolling basis directly to
18 eligible providers, including laboratories. The HRSA COVID-19
19 Uninsured Program was a "health care benefit program" as defined in
20 18 U.S.C. § 24(b) in that it was a public plan or contract affecting
21 commerce, and a "Federal health care program" as defined by 42 U.S.C.
22 § 1320a-7b(f).

23 23. In order to receive reimbursement under the HRSA COVID-19
24 Uninsured Program, a provider was required to attest to compliance
25 with the Terms and Conditions of the program. The terms and
26 conditions required the provider to submit truthful claims, in
27 respect to uninsured individuals, for: (1) COVID-19 testing, which
28 was defined as a test for the detection of SARS-CoV-2 or the

1 diagnosis of the virus that causes COVID-19, and/or testing-related
2 items and services such as an office visit or a telehealth visit that
3 resulted in the administration of a COVID-19 test; (2) care or
4 treatment related to positive diagnoses of COVID-19, where COVID-19
5 was the primary reason for treatment; or (3) administering a COVID-19
6 vaccination.

7 24. Providers seeking reimbursement under the HRSA COVID-19
8 Uninsured Program were required to enroll as a provider participant,
9 check to ensure that patients were uninsured, submit claims and
10 patient information electronically, and receive payment through
11 direct deposit. Reimbursements were generally made at Medicare
12 rates.

13 25. Claims submitted electronically to the COVID-19 Uninsured
14 Program and payments made from the COVID-19 Uninsured Program were
15 transmitted through interstate wires.

16 Exclusion From Federal Health Care Programs

17 26. HHS was required to exclude any individual or entity from
18 participating in all Federal health care programs upon conviction for
19 certain crimes, including a criminal offense related to the delivery
20 of an item or service under Medicare or any State health care
21 program, or a felony conviction related to health care fraud or other
22 financial misconduct ("mandatory exclusion"). 42 U.S.C. § 1320a-
23 7(a).

24 27. HHS also possessed discretionary exclusion authority. HHS
25 could exclude an entity from participation in Medicare under certain
26 circumstances, including where a person who had a direct or indirect
27 ownership or control interest of five percent or more in the entity,
28 or was an officer, director, agent, or managing employee of the

1 entity, (i) had been convicted of certain crimes, including all
2 crimes that would subject a person to mandatory exclusion, or (ii)
3 had been excluded from participation in Federal health care programs.
4 42 U.S.C. § 1320a-7(b)(8). HHS could also exclude any entity that
5 did not fully and accurately make any disclosure required by 42
6 U.S.C. § 1320a-3. 42 U.S.C. § 1320a-7(b)(9).

7 28. The effect of exclusion was to prohibit the payment by any
8 Federal health care program for any items or services the excluded
9 person or entity furnished, ordered, or prescribed in any capacity.
10 Excluded persons were also prohibited from furnishing administrative
11 and management services, including health information technology
12 services, strategic planning, billing, and human resources, even if
13 the services did not directly involve patient care or the provision
14 of any health care related services.

15 29. Reinstatement following exclusion from Medicare was not
16 automatic. An excluded person was required to apply for and be
17 granted reinstatement by HHS.

18 Convictions and Exclusions of Defendant NAVARRO and Shams

19 30. On or about August 23, 1990, the United States District
20 Court for Eastern District of New York entered a judgment of
21 conviction against Shams, in case no. 9:89-cr-667, for Medicaid
22 fraud.

23 31. On or about July 22, 1991, as a consequence of Shams's
24 conviction in the Eastern District of New York, the Department of
25 Health and Human Services, Office of Inspector General ("HHS-OIG")
26 excluded Shams from participation in Medicare, Medicaid, and all
27 other Federal health care programs for a period of five years. At
28 the time of the exclusion, HHS-OIG informed Shams in writing that the

1 effect of the exclusion included that no payment would be made to any
2 entity in which he served as an employee, administrator, operator, or
3 in any other capacity for any services furnished after the effective
4 date of the exclusion, and further informed him that in order to
5 apply for reinstatement, he must make a request in writing to HHS-
6 OIG, which would notify him about any decision on reinstatement.

7 32. On or about December 20, 2001, the Superior Court of
8 California, County of Orange, in case nos. 00WF1386FA, 00WF0152FA,
9 00WF1387FA, 00WF1385FA, and 00WF1763FA, entered a judgment of
10 conviction against Shams for felony grand theft related to billing
11 fraud involving Medicare and the Medi-Cal program, a State health
12 care program as defined by 42 U.S.C. § 1320a-7(h) that provided free
13 or reduced cost health care benefits to low income and other
14 qualifying persons in California.

15 33. On or about August 19, 2004, as a consequence of Shams's
16 conviction in the Orange County Superior Court, HHS-OIG excluded
17 Shams from participation in Medicare, Medicaid, and all other Federal
18 health care programs for a period of ten years. At the time of the
19 exclusion, HHS-OIG informed Shams in writing that the effect of the
20 exclusion included that no payment would be made to any employer for
21 anything that he did, ordered, or prescribed to program patients.
22 HHS-OIG further informed him that reinstatement was not automatic,
23 that he would have to apply in writing to HHS-OIG for reinstatement,
24 and that he would have to await a decision by HHS-OIG on his
25 reinstatement.

26 34. Shams did not apply to HHS-OIG for reinstatement following
27 the 1991 and 2004 exclusions, and he remained an excluded individual.

1 35. On or about November 16, 2017, in case no. 17-cr-558, in
2 the United States District Court for the Eastern District of New
3 York, Shams entered a plea of guilty to an Information charging
4 conspiracy to commit money laundering, conspiracy to receive and pay
5 health care kickbacks, and conspiracy to defraud by obstructing the
6 lawful functions of the Internal Revenue Service.

7 36. On or about May 23, 2000, the Superior Court of California,
8 County of Orange, in case nos. GA040021, GA040022, DJ00WF0152, and
9 LA035275, entered judgments of conviction against defendant NAVARRO
10 for felony grand theft related to billing fraud involving the
11 Medicare and Medi-Cal programs.

12 37. On or about September 30, 2002, as a consequence of
13 defendant NAVARRO's conviction in the Orange County Superior Court,
14 HHS-OIG excluded defendant NAVARRO from participation in Medicare,
15 Medicaid, and all other federal health care programs for a period of
16 15 years. At the time of the exclusion, HHS-OIG informed defendant
17 NAVARRO in writing that the effect of the exclusion included that no
18 payment would be made to any employer for anything that she did,
19 ordered, or prescribed to program patients. HHS-OIG further informed
20 her that reinstatement was not automatic, that she would have to
21 apply in writing to HHS-OIG for reinstatement, and that she would
22 have to await a decision by HHS-OIG on her reinstatement.

23 Reinstatement of Defendant NAVARRO

24 38. On or about September 27, 2018, 16 years after defendant
25 NAVARRO had been excluded from Medicare, defendant NAVARRO,
26 indicating an address in the Central District of California,
27 submitted a letter to HHS-OIG requesting reinstatement to Medicare.
28

1 39. On or about October 1, 2018, HHS-OIG responded in a letter
2 to defendant NAVARRO, at an address in the Central District of
3 California, stating that in order to apply for reinstatement,
4 defendant NAVARRO was required to respond to each question in an
5 Application for Reinstatement to Federal Health Care Program
6 Participation ("Application for Reinstatement") and provide her
7 entire work history since the effective date of the exclusion,
8 including "all health care employment." The letter advised that
9 defendant NAVARRO could not participate "in any capacity, in the
10 Medicare, Medicaid, or any Federal health care programs" until HHS-
11 OIG provided written notice of reinstatement.

12 40. On or about November 6, 2018, defendant NAVARRO submitted a
13 false and fraudulent Application for Reinstatement to HHS-OIG that
14 falsely stated, among other things, that defendant NAVARRO had not
15 owned or operated a health care entity, or served as a manager,
16 administrator, or director of any entity that furnished health care
17 items or services, during the period of her exclusion. In reliance
18 on this false and fraudulent application, on or about December 14,
19 2018, HHS-OIG reinstated defendant NAVARRO.

20 Insurance Company-1

21 41. Insurance Company-1 was an integrated health management
22 organization that provided health care and health care coverage to
23 its members in California and other states. In addition to providing
24 coverage to its members, Insurance Company-1 contracted with CMS to
25 provide managed care to Medicare Advantage beneficiaries through
26 various plans.

1 42. Insurance Company-1 was a "health care benefit program" as
2 defined in 18 U.S.C. § 24(b), in that it was a private plan or
3 contract affecting commerce.

4 43. Insurance Company-1 reimbursed physicians, clinical
5 laboratories, and other health care providers for medical items and
6 services provided to members of Insurance Company-1 and Medicare
7 Advantage beneficiaries enrolled in its various plans, and paid for
8 claims only if the items and services were medically necessary and
9 provided as represented.

10 Laboratory Testing

11 44. Clinical laboratories such as Matias performed various
12 types of tests, such as toxicology screens, urinalysis, routine blood
13 work, and tests for respiratory pathogens. These tests were
14 performed on urine, blood, and saliva samples, and nasal swabs
15 ("specimens"). Physicians, nurse practitioners, and other authorized
16 providers could issue orders ("doctors' orders") for laboratory
17 testing for Medicare beneficiaries and other patients.

18 45. Laboratories could perform tests to detect whether an
19 individual had COVID-19. Laboratories could also perform tests to
20 detect a variety of viral and bacterial respiratory pathogens. Tests
21 for respiratory pathogens were sometimes performed in "panels" that
22 targeted multiple pathogens, known as a respiratory pathogen panel
23 ("RPP"). Panels could be designed to test different numbers of
24 pathogens, and could also include a test for COVID-19.

25 46. Claims for reimbursement of laboratory tests were submitted
26 to Medicare, other Federal health care programs, and private insurers
27 using Common Procedural Terminology ("CPT") codes, a set of
28 standardized codes used by medical professionals, laboratories, and

1 other medical providers to describe the services they provided.
2 There were CPT codes for RPPs that targeted multiple pathogens, as
3 well as codes for the individual pathogens that could be included in
4 a panel.

5 47. In general, the amounts Medicare, HRSA, and private
6 insurers reimbursed laboratories for RPP and other respiratory
7 pathogen testing were several times higher than the amounts they
8 reimbursed for COVID-19 testing.

9 B. OBJECTS OF THE CONSPIRACY

10 48. Beginning in or around the middle of 2018, and continuing
11 through April 19, 2022, in Los Angeles County, within the Central
12 District of California, and elsewhere, defendant NAVARRO knowingly
13 conspired with Shams and others known and unknown to the Grand Jury,
14 to commit health care fraud and wire fraud, in violation of Title 18,
15 United States Code, Sections 1347 and 1343.

16 C. THE MANNER AND MEANS OF THE CONSPIRACY

17 49. The objects of the conspiracy were carried out, and to be
18 carried out, in substance, as follows:

19 a. Defendant NAVARRO and Shams, despite being excluded
20 from participation in all Federal health care programs, maintained an
21 ownership interest in, exercised management and control of, and
22 provided administrative and management services to, Matias, a
23 provider that submitted claims for reimbursement of laboratory
24 testing services to Medicare and other Federal health care programs.

25 b. Defendant NAVARRO and Shams, for the purpose of
26 enabling Matias to maintain billing privileges and receive
27 reimbursements from Medicare and other Federal health care programs,
28 fraudulently concealed defendant NAVARRO and Shams's roles in Matias

1 from Medicare by failing to submit enrollment information disclosing:
2 (i) defendant NAVARRO and Shams's assumption of an ownership and
3 control interest; (ii) defendant NAVARRO and Shams's status as
4 excluded persons; and (iii) defendant NAVARRO and Shams's prior
5 convictions of multiple federal and state health care fraud offenses.

6 c. Defendant NAVARRO and Shams fraudulently submitted and
7 caused to be submitted to Medicare enrollment and other documents
8 that: (i) falsely identified Individual A as the only person with a
9 five percent or greater ownership interest or managing control in
10 Matias; (ii) falsely identified Individual A and Individual B as the
11 only officers of Matias; (iii) concealed and disguised defendant
12 NAVARRO and Shams's ownership, control, managerial positions, and
13 roles in Matias; and (iv) concealed and disguised defendant NAVARRO
14 and Shams's prior convictions.

15 d. Defendant NAVARRO and Shams fraudulently submitted and
16 caused to be submitted to the California Department of Public Health
17 documents that: (i) falsely stated that no individuals who were
18 managing employees of the laboratory had designated criminal
19 convictions; and (ii) concealed and disguised defendant NAVARRO and
20 Shams's roles as officers, directors, or persons responsible to
21 manage or conduct the day-to-day operations of Matias.

22 e. Defendant NAVARRO, in an Application for Reinstatement
23 submitted to HHS-OIG on or about November 6, 2018, falsely concealed
24 her operation and management of Matias, and made other false
25 statements, so that Matias could continue receiving reimbursements
26 from Medicare and other Federal health care programs.

27 f. Defendant NAVARRO and Shams paid and caused to be paid
28 illegal kickbacks and bribes to purported marketers and others in

1 exchange for specimens and doctors' orders, so that Matias could
2 perform laboratory tests, including COVID-19 and RPP tests, and
3 submit claims for reimbursement to Federal health care programs,
4 including Medicare and HRSA.

5 g. After the COVID-19 pandemic began, defendant NAVARRO
6 and Shams obtained nasal swab specimens that enabled Matias to test
7 for the presence of SARS-CoV-2, the virus that causes COVID-19 (the
8 "COVID-19 Specimens"), as well as testing orders from physicians and
9 other medical professionals. The COVID-19 Specimens were collected
10 from, among others, residents and staff at nursing homes, assisted
11 living facilities, rehabilitation facilities, and similar types of
12 facilities, and from students and staff at schools in the Los Angeles
13 area, for the purported purpose of conducting screening tests to
14 identify and isolate individuals infected with COVID-19.

15 h. Defendant NAVARRO and Shams routinely caused various
16 RPP tests to be performed on the COVID-19 Specimens that had been
17 collected for the purpose of performing COVID-19 screening tests,
18 even though physicians and medical professionals ordered testing only
19 for COVID-19, and even though it was not medically necessary to
20 conduct RPP tests on asymptomatic individuals who were being screened
21 to identify COVID-19 infections.

22 i. Defendant NAVARRO and Shams submitted and caused to be
23 submitted to Medicare, HRSA, and Insurance Company-1 false and
24 fraudulent claims for the aforementioned RPP tests performed on the
25 COVID-19 Specimens, in that the claims were submitted for tests that
26 were not ordered as represented, medically unnecessary, procured
27 through the payment of kickbacks and bribes, and ineligible for
28 reimbursement. The claims were submitted through CPT codes

1 representing panels of tests as well through CPT codes representing
2 individual respiratory pathogens.

3 j. Defendant NAVARRO and Shams caused the creation of
4 false and fraudulent test requisitions that purportedly reflected the
5 ordering of RPP tests, when in truth and in fact, physicians and
6 other medical professionals had ordered only COVID-19 tests.

7 k. Defendant NAVARRO and Shams caused false and
8 fraudulent claims for RPP tests to be submitted to HRSA by
9 representing that the tested individuals had been diagnosed with
10 COVID-19, when in truth and in fact, the individuals had not been
11 diagnosed with COVID-19 and the tests were for screening purposes
12 only.

13 l. Defendant NAVARRO and Shams caused Medicare, HRSA, and
14 Insurance Company-1's reimbursements on Matias' fraudulent claims to
15 be deposited into Matias' bank accounts, from which defendant NAVARRO
16 and Shams made large cash withdrawals and caused transfers to be made
17 to other bank accounts they controlled to fund purchases of real
18 estate, luxury items, travel, and household expenses.

19 50. Between approximately August 2018 and April 2022, defendant
20 NAVARRO and Shams caused Matias to submit to Medicare false and
21 fraudulent claims in the approximate amount of \$234 million for
22 laboratory tests, including COVID-19 tests, RPP tests, and other
23 tests, that were not ordered as represented, medically unnecessary,
24 procured through the payment of kickbacks and bribes, and ineligible
25 for reimbursement. As a result of these false and fraudulent claims,
26 Medicare made payments to Matias in the approximate amount of \$31.7
27 million.

1 51. Of the amounts set forth in paragraph 50, defendant NAVARRO
2 and Shams caused Matias to submit to Medicare, after the onset of the
3 COVID-19 pandemic, false and fraudulent claims in the approximate
4 amount of \$138 million for RPP tests that were not ordered as
5 represented, medically unnecessary, procured through the payment of
6 kickbacks and bribes, and ineligible for reimbursement. As a result
7 of these false and fraudulent claims, Medicare reimbursed Matias in
8 the approximate amount of \$16.9 million.

9 52. Between approximately September 2020 and April 2022,
10 defendant NAVARRO and Shams caused Matias to submit to HRSA, through
11 interstate wire transmissions, false and fraudulent claims in the
12 approximate amount of \$182.8 million for RPP tests that were not
13 ordered as represented, medically unnecessary, procured through the
14 payment of kickbacks and bribes, and ineligible for reimbursement.
15 As a result of these false and fraudulent claims, HRSA made payments
16 to Matias in the approximate amount of \$25.2 million.

17 53. Between approximately June 2020 and December 2021,
18 defendant NAVARRO and Shams caused Matias to submit to Insurance
19 Company-1, for both Medicare Advantage beneficiaries and members
20 insured directly by Insurance Company-1, false and fraudulent claims
21 in the approximate amount of \$38.4 million for RPP tests that were
22 not ordered as represented, medically unnecessary, procured through
23 the payment of kickbacks and bribes, and ineligible for
24 reimbursement. As a result of these false and fraudulent claims,
25 Insurance Company-1 made payments to Matias in the approximate amount
26 of \$12.2 million.

27 54. In total, defendant NAVARRO and Shams caused Matias to
28 submit false and fraudulent claims to Medicare, HRSA, and Insurance

1 Company-1 in the approximate amount of \$455.2 million, resulting in
2 payments to Matias in the approximate amount of \$69.1 million.

COUNTS TWO THROUGH SEVEN

[18 U.S.C. §§ 1347, 2(b)]

55. The Grand Jury incorporates paragraphs 1 through 47 and 49 through 54 of this First Superseding Indictment here.

A. THE SCHEME TO DEFRAUD

56. Beginning in or around the middle of 2018, and continuing through April 19, 2022, in Los Angeles County, within the Central District of California, and elsewhere, defendant NAVARRO, together with Shams and others known and unknown to the Grand Jury, each aiding and abetting the others, knowingly, willfully, and with the intent to defraud, executed a scheme and artifice: (1) to defraud health care benefit programs, namely, Medicare, the HRSA COVID-19 Uninsured Program, and Insurance Company-1; and (2) to obtain money from health care benefit programs, namely, Medicare, the HRSA COVID-19 Uninsured Program, and Insurance Company-1, by means of materially false and fraudulent pretenses, representations, and promises, and the concealment of material facts, both in connection with the delivery of and payment for health care benefits, items, and services.

57. The fraudulent scheme operated, in substance, as described in paragraphs 50 through 55 of this First Superseding Indictment.

B. EXECUTION OF THE SCHEME TO DEFRAUD

58. On or about the dates set forth below, within the Central District of California, and elsewhere, defendant NAVARRO, together with Shams and others known and unknown to the Grand Jury, aiding and abetting each other, knowingly and willfully executed and willfully caused the execution of the fraudulent scheme described above by submitting and causing to be submitted to Medicare, the HRSA COVID-19

Uninsured Program, and Insurance Company-1 the false and fraudulent claims identified below:

COUNT	CLAIM NO.	APPROX. DATE CLAIM SUBMITTED	INSURER	SERVICES BILLED	APPROX. AMOUNT BILLED	APPROX. AMOUNT PAID	BENE-FICIARY
TWO	551121 209403 360	07/28/ 2021	Medicare	Respiratory pathogen testing	\$2,829	\$448	S.M.
THREE	551121 054050 740	02/23/ 2021	Medicare	Respiratory pathogen testing	\$2,829	\$448	J.G.
FOUR	551121 214260 260	07/31/ 2021	Medicare	Respiratory pathogen testing	\$2,829	\$448	E.C.
FIVE	DE0286 6393	01/20/ 2022	HRSA	Respiratory pathogen testing	\$2,217	\$306	J.M.
SIX	DE3385 4122	01/28/ 2022	HRSA	Respiratory pathogen testing	\$2,217	\$306	B.L.
SEVEN	401732 9880	05/13/ 2021	Insurance Company-1	Respiratory pathogen testing	\$2,971	\$1,841	L.H.

COUNT EIGHT

[18 U.S.C. § 1956(h)]

60. The Grand Jury incorporates paragraphs 1 through 47 and 49 through 54 of this First Superseding Indictment here.

61. Nurse Plus, dba Specialty Infusion Services ("Nurse Plus"), was a California corporation with an address at 3345 Wilshire Boulevard, Suite 407, Los Angeles, California 90010. Defendant NAVARRO owned, controlled, and operated Nurse Plus.

62. Proworx LLC ("Proworx") was a Delaware company, registered to do business in New York, with an address at 41 El Camino Loop, Staten Island, New York 10309. Defendant NAVARRO owned, controlled, and operated Proworx.

A. OBJECTS OF THE CONSPIRACY

63. Beginning in or around the middle of 2018, and continuing through April 19, 2022, in Los Angeles County, within the Central District of California, and elsewhere, defendant NAVARRO, Shams, and others known and unknown to the Grand Jury, knowingly conspired to commit the following offenses against the United States:

a. Knowing that property involved in financial transactions affecting interstate and foreign commerce represented the proceeds of some form of unlawful activity, and which property was, in fact, the proceeds of a specified unlawful activity, namely, conspiracy to commit health care fraud and wire fraud, in violation of 18 U.S.C. § 1349, and health care fraud, in violation of 18 U.S.C. § 1347, conducting, attempting to conduct, and willfully causing others to conduct and attempt to conduct financial transactions affecting interstate commerce, knowing that the transactions were designed in whole and in part to conceal and disguise the nature,

1 location, source, ownership, and control of the proceeds of such
2 specified unlawful activity, in violation of Title 18, United States
3 Code, Section 1956(a)(1)(B)(i); and

4 b. knowingly engaging and attempting to engage in
5 monetary transactions involving criminally derived property of a
6 value greater than \$10,000, which property represented the proceeds
7 of specified unlawful activity, namely, conspiracy to commit health
8 care fraud and wire fraud, in violation of 18 U.S.C. § 1349, and
9 health care fraud, in violation of 18 U.S.C. § 1347, in violation of
10 Title 18, United States Code, Section 1957.

11 B. THE MANNER AND MEANS OF THE CONSPIRACY

12 64. The objects of the conspiracy were carried out, and to be
13 carried out, in substance, as follows:

14 a. As described in paragraphs 49 through 54 of this First
15 Superseding Indictment, defendant NAVARRO and Shams caused the
16 submission of false and fraudulent claims to Medicare, HRSA, and
17 Insurance Company-1, resulting in those payors depositing payments
18 for such claims into Matias's bank account.

19 b. Defendant NAVARRO and Shams withdrew, transferred, and
20 caused the transfer of Medicare, HRSA, and Insurance Company-1 funds
21 that were deposited into the Matias WF x7139 account and the Matias
22 EW x5549 account, which constituted the proceeds of conspiracy to
23 commit health care fraud and wire fraud, and health care fraud, as
24 follows:

25 i. Defendant NAVARRO and Shams made and caused to be
26 made cash withdrawals, often in excess of \$10,000.

27 ii. Defendant NAVARRO and Shams transferred and
28 caused to be transferred funds for the purpose of engaging in real

1 estate transactions involving properties in the names of other
2 individuals.

3 iii. Defendant NAVARRO and Shams transferred and
4 caused to be transferred funds to bank accounts controlled by
5 defendant NAVARRO in the names of Nurse Plus and Proworx, which were
6 shell companies controlled by defendant NAVARRO, after which
7 defendant NAVARRO and Shams made and caused to be made further
8 transfers out of those accounts, often in amounts exceeding \$10,000,
9 to fund real estate transactions and to purchase luxury items and
10 goods and services for their personal use.

11 iv. Defendant NAVARRO and Shams transferred and
12 caused to be transferred funds to an account at East West Bank ending
13 in 6273, in the name of Shams, who in turn made multiple transfers
14 out of the account in excess of \$10,000, including a wire transfer to
15 an overseas location.

COUNT NINE

[18 U.S.C. § 1001(a)(3)]

65. The Grand Jury incorporates paragraphs 1 through 47 and 49 through 54 of this First Superseding Indictment here.

66. On or about November 6, 2018, in Los Angeles County, within the Central District of California, in a matter within the jurisdiction of the executive branch of the government of the United States, namely, HHS-OIG, defendant NAVARRO knowingly and willfully made a false writing and document, namely, an Application for Reinstatement, knowing the same to contain materially false, fictitious, and fraudulent statements and entries, as follows:

a. In response to Question 8 on the Application for Reinstatement, which asked the respondent, "During your period of exclusion did you own any health care related entity, operate any health care related entity, or serve as a manager, administrator, or director of any entity that furnished health care services?" defendant NAVARRO wrote "NO." In fact, as defendant NAVARRO knew, during the period of her exclusion, defendant NAVARRO had operated and managed entities that furnished health care services.

b. In response to Question 16 on the Application for Reinstatement, which asked the respondent, "Please list any and all employment (health care, non-health care, part-time, self-employment, etc.) and all periods of unemployment" during the entire period of the exclusion "to the present," defendant NAVARRO wrote "2013 - onwards Housewife." In fact, as defendant NAVARRO knew, between 2013 and the date of the Application, defendant NAVARRO had operated and managed entities that furnished health care services.

FORFEITURE ALLEGATION ONE

[18 U.S.C. § 982(a)(7)]

1. Pursuant to Rule 32.2(a), Fed. R. Crim. P., notice is hereby given that the United States will seek forfeiture as part of any sentence, pursuant to Title 18, United States Code, Section 982(a)(7), in the event of the defendant's conviction of the offenses set forth in any of Counts One through Seven or Count Nine of this First Superseding Indictment.

2. The defendant, if so convicted, shall forfeit to the United States of America the following:

(a) All right, title, and interest in any and all property, real or personal, that constitutes or is derived, directly or indirectly, from the gross proceeds traceable to the commission of any offense of conviction; and

(b) To the extent such property is not available for forfeiture, a sum of money equal to the total value of the property described in subparagraph (a).

3. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b), the defendant, if convicted shall forfeit substitute property, up to the total value of the property described in the preceding paragraph if, as a result of any act or omission of the defendant, the property described in the preceding paragraph, or any portion thereof (a) cannot be located upon the exercise of due diligence; (b) has been transferred, sold to, or deposited with a third party; (c) has been placed beyond the jurisdiction of the Court; (d) has been substantially diminished in value; or (e) has been commingled with other property that cannot be divided without difficulty.

FORFEITURE ALLEGATION TWO

[18 U.S.C. § 982(a)(1)]

1. Pursuant to Rule 32.2 of the Federal Rules of Criminal Procedure, notice is hereby given that the United States will seek forfeiture as part of any sentence, pursuant to Title 18, United States Code, Section 982(a)(1), in the event of the defendant's conviction of the offense set forth in Count Eight of this First Superseding Indictment.

2. The defendant, if so convicted, shall forfeit to the United States of America the following:

(a) Any property, real or personal, involved in such offense, and any property traceable to such property; and

(b) To the extent such property is not available for forfeiture, a sum of money equal to the total value of the property described in subparagraph (a).


3. Pursuant to Title 21, United States Code, Section 853(p), as incorporated by Title 28, United States Code, Section 982(b)(1), and Title 18, United States Code, Section 982(b)(2), the defendant, if so convicted, shall forfeit substitute property, if, by any act or omission of the defendant, the property described in the preceding paragraph, or any portion thereof (a) cannot be located upon the exercise of due diligence; (b) has been transferred, sold to, or deposited with a third party; (c) has been placed beyond the jurisdiction of the court; (d) has been substantially diminished in value; or (e) has been commingled with other property that cannot be divided without difficulty. Substitution of assets shall not be ordered, however, where the defendant acted merely as an intermediary who handled but did not retain the property in the course of the

1 money laundering offense unless the defendant, in committing the
2 offense or offenses giving rise to the forfeiture, conducted three or
3 more separate transactions involving a total of \$100,000.00 or more
4 in any twelve-month period.

5
6 A TRUE BILL

7
8 /s/
9 Foreperson

10 E. MARTIN ESTRADA
11 United States Attorney

12 
13 *Scott M. Garringer*
14 *Deputy Chief, Criminal Division For:*

15 MACK E. JENKINS
16 Assistant United States Attorney
17 Chief, Criminal Division

18 RANEE A. KATZENSTEIN
19 Assistant United States Attorney
20 Chief, Major Frauds Section

21 GLENN S. LEON
22 Chief, Fraud Section
23 U.S. Department of Justice

24 NIALL M. O'DONNELL
25 Assistant Chief, Fraud Section
26 U.S. Department of Justice

27 GARY A. WINTERS
28 RAYMOND E. BECKERING III
Trial Attorneys, Fraud Section
U.S. Department of Justice